

Armfield Dentistry

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. We do not use this information to discriminate.

Today's Date _____

Patient's name _____ Preferred name _____ Birth date _____

If minor, Mothers name _____ Fathers name _____

Home phone _____ Work phone _____ Cell _____

Email _____ Male Female

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ Unmarried

Spouse phone _____ Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co. _____ Group number _____

Covered by spouse's insurance? yes no Dental ID# _____

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check any that apply)

- Cancer/Chemotherapy/ or tumor
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial heart valve
- Sleep Apnea
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis B or C or other liver disease
- Current or previous substance abuse
- Blood transfusion If yes, what date: _____
- Diabetes type I or II
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition If yes, Describe _____
- Autism
- Multiple Sclerosis (MS)
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma or COPD
- Persistent swollen glands in neck/Thyroid
- Recurrent infections
- Eating Disorder

Do you smoke or use chewing tobacco? yes no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
If so, what? _____
- Local anesthetics
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Injections for Actonel, Boniva, Fosamax, Zometa, or Aredia
- Narcotics (Lortab, Norco, Tramadol, Morphine, etc)
- Preferred Pharmacy _____
- Please list prescriptions on seperate page provided

Women:

- May be pregnant
Expected delivery date: _____
- Taking hormones, contraceptives, implant

Name: _____ DOB _____ ID# _____

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

- | | |
|--|---|
| <input type="checkbox"/> Do your gums bleed when you brush or floss? | <input type="checkbox"/> Drink carbonated, sports, or energy drinks on regular basis? |
| <input type="checkbox"/> Sensitivity to cold, hot, sweets or pressure? | <input type="checkbox"/> Have you ever had a serious injury to your head or mouth? |
| <input type="checkbox"/> Food or Floss catch between your teeth? | <input type="checkbox"/> Suck finger or thumb? |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Nail biting? |
| <input type="checkbox"/> Had periodontal (gum) treatments? | <input type="checkbox"/> Nursing bottle habits? |
| <input type="checkbox"/> Previous orthodontic (braces) treatment? | <input type="checkbox"/> Date of your last dental exam: _____ |
| <input type="checkbox"/> Any problems associated with previous dental treatment? | <input type="checkbox"/> What was done at that time? _____ |
| <input type="checkbox"/> Do you brux or grind your teeth? | <input type="checkbox"/> Date of last dental x-rays: _____ |
| <input type="checkbox"/> Do you have sores or ulcers in your mouth? | <input type="checkbox"/> Where: _____ |
| <input type="checkbox"/> Do you wear partials or dentures? | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Are you currently experiencing dental pain or discomfort? | |
| <input type="checkbox"/> Do you have earaches or neck pains? | |

Your health and well being is very important to us. We appreciate the confidence and trust that you have placed in us. Please read our policies and feel free to ask any questions.

Broken/Missed Appointments: We request at least 48 hours' notice before cancelling or rescheduling an appointment. That way, we have some time to try and care for another patient. We will allow ONE (1) rescheduled appointment per patient. If you do not show or call to reschedule an appointment, unfortunately we will not be able to reschedule your appointment. It is very important to schedule appointments that will fit into your schedule.

Confirmation Policy

If our office is unable to confirm your dental appointment verbally or electronically with you, we do reserve the right to cancel your appointment and reappoint to another patient. Please be sure to keep us in mind when you change your phone, work or cellular phone numbers to avoid this situation.

Cell# _____ Can you receive text messages? **yes** or **no**

Contact info for someone living outside the home: Name _____ # _____

Minor/Child Office and Treatment Policy

In our office, we ask that parent(s) stay in the reception area while we are treating your child. Experience has shown that children do much better with a "one-on-one" setting. We invite you to take a tour of our office if you would like. You will be asked to go back to the treatment area during your child's examinations, or if necessary, during any future visits. Please be assured that we will do everything possible to make your child's visits comfortable and enjoyable.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I have received a copy (or been offered a copy) of this office's Notice of Privacy Practices.

Please Print Name: _____ Signature: _____

Date: ____/____/____

Other family members: _____